



WIC & Medicaid Enteral Nutrition & Supplemental Foods Prescription (Rev.) 10.6.09

WIC Local Agency _____ "Primary" WIC Agency (if different) _____

Health Care Provider Use Only (Items 1-5)

1. Client Name _____ DOB _____
 Medicaid Eligible (check one) Y ☐ N ☐ End Date _____ Medicaid Recipient # _____
2. Parent's/Caregiver's Name: _____
3. Formula Name: _____ Amount of formula needed/day _____ (oz) See Item #3 on the back of this page to choose the amount of formula needed based on the infant's age Duration of Use _____ [Up to 1 year]
 Was another formula tried and it didn't work? (check one) Y ☐ N ☐ Formula tried _____

Supplemental Foods for Infants Check Full Food Package, Food Restricted or Formula Only
Supplemental Foods for Children & Women Check Full Food Package or Food Restricted

Infants (6-11 months)

- ☐ Full Food Package [check when client can eat all foods]
 or
☐ Food Restricted [check food(s) to avoid]
☐ Infant Cereal
☐ Infant Fruits/Vegetables
 or
☐ Formula Only [check when infant can only have formula]
 Duration _____ [Up to 1 year]

Children & Women

- ☐ Full Food Package [check when client can eat all foods]
 or
☐ Food Restricted [check food(s) to avoid]
☐ Fruits/Vegetables ☐ Juice ☐ Milk-Fat Reduced
☐ Eggs ☐ Cheese ☐ Breakfast Cereal
☐ Fish (canned) ☐ Fruits/Vegetables
☐ Whole Wheat Bread or Other Whole Grains
☐ Legumes ☐ Peanut Butter
 Duration _____ [Up to 1 year]

- ☐ Milk Substitutes for Children and Women need a medical diagnosis, qualifying condition or religious eating patterns [may check more than one milk substitute]
☐ Soy Based Beverage ☐ Tofu ☐ Whole Milk ☐ Cheese (monthly amount ☐ 2# ☐ 3# ☐ 4#)
 Duration _____ [Up to 1 year]

4. Medical Diagnosis ICD-9-CM or Qualifying Condition (Circle at least one or write in space provided)

- | | |
|--|--|
| a. Failure to Thrive (783.41) 134 | m. Lactose intolerance (271.3) 355 |
| b. Inadequate Growth (783.40) 135 | n. Celiac Disease (579.0) 354 |
| c. Underweight (783.22) 103 | o. Heart/circulatory or respiratory diseases (390-519) 355 |
| d. Prematurity (765.10) 142 | p. Persistent dermatological condition (692.9) 353 |
| e. Low Birth Weight (LBW) (765.10) 141 | q. Anaphylactic shock (995.60-995.69) 353 |
| f. Anemia (281.9) 201 | r. Developmental Sensory/Motor Delays (783.4) 362 |
| g. Severe Gastrointestinal Disorders (536.9) 342 | s. Fetal Alcohol Syndrome (760.71) 382 |
| h. Malabsorption Syndromes (579.9) 349 | t. Vegan Diet |
| i. Genetic-Congenital Disorders (740-759) 349 | u. Low Maternal Weight Gain (646.8) 131 |
| j. Metabolic Disorders or Inborn Errors of Amino Acid Metabolism (277.9) 351 | v. Maternal Weight Loss During Pregnancy (783.2) 103 |
| k. Severe Food Allergies (693.1) 353 | w. Multifetal Gestation (651) 335 |
| l. Milk, Soy or Corn Allergies (693.1) 353 | x. Other Medical Conditions (ICD-9 _____) |

5. Medical Provider Signature Date Provider's Medicaid or Alaska License

Print Medical Provider's Name

Print or Stamp Address and Phone #

Registered Dietitian/Licensed Dietitian (RD/LD) & Medicaid Use Only

Height _____ (in) or _____ (cm) (1 in = 2.54 cm) Weight _____ (lbs) or _____ (kg) (1 kg = 2.2 lbs)

Daily Caloric Needs Range for 6 months _____ kcal) RD Initials _____ Date _____ Incomplete _____

WIC LA Staff Initials _____ Approved _____ Denied _____ Date Range Approved For: _____

(Optional: Pharmacy Use Only) Recommended Amount of _____ (product name) Size of product _____

Number of cans: Per day _____ Per Month _____ Pharmacist signature _____ Date _____

Affiliated Computer Services Action Date: _____ (check one) ☐ Authorized ☐ Denied

Instructions for Physicians, Physician Assistants or Nurse Practitioners to Complete an ENPR

(Only Healthcare Providers licensed to write a prescription in Alaska can complete an ENPR)

Item #1: Write patient's complete name, date of birth (DOB) and Medicaid Information.

Item #2: Write patient's parent/caregivers name.

Item #3: Write the formula, the amount of formula needed and how long the patient needs it.

Refer to the daily guidelines below. A request is valid up to a year.

Daily Guidelines for Feeding Iron-Fortified Infant Formula to Healthy Infants, Birth to 1 Year Old

Birth – 4 months	14 – 42 ounces (108 kcal/kg/d)	6-8 months	24 – 32 ounces (98 kcal/kg/d)
4-6 months	26 – 39 ounces (108 kcal/kg/d)	8- 12 months	24 – 32 ounces (98 kcal/kg/d)

Prescribe Supplemental foods for your patient. Choose a **Full or Restricted Food Package**.

If you choose a Restricted Food Package, check the foods the patient needs to avoid.

Milk Substitutes Request for Children & Women need a medical diagnosis or a qualifying condition (i.e. Vegan Diet)

Item #4: Determine and circle one or more serious medical or qualifying conditions listed.

Other Medical Conditions must have an ICD-9 code or qualifying conditions.

Item #5: A Health Care Provider's **original signature** is required.

Print or stamp your name, address and phone number. By signing this form, you are verifying you have seen and evaluated the patient's nutrition and feeding problem(s) and symptoms determining he/she has a serious medical condition or qualifying condition. Give the completed form to the parent or guardian to take to their WIC clinic or fax it to the WIC Clinic serving the patient. **For hard copies go**

<http://www.hss.state.ak.us/dpa/programs/nutri/WIC/LocalAgencies/LAENPRForms.htm>.

Instructions for the Registered/Licensed Dietitian (RD/LD) or Competent Professional Authority (CPA) in consultation with RD/LD

1. Verify the ENPR is complete.
2. Verify the formula/medical food requested is on the approved Alaska WIC non-contract formula list. Verify that the supplemental food approval section is filled out if needed.
3. Using the RDA, RD estimates and writes **current** daily caloric needs, calorie needs in **6 months** and **range of calories needed per day within six months**. Amounts of supplemental foods contribute to the participant's total caloric needs.

Recommended Dietary Allowances (RDA) Average Estimation

Low Birth Weight Infant (120 kcal/kg/d)	1-3 yr (102 kcal/kg/d)	Female 25-50 (36 kcal/kg/d)
Full Term 0-6 months (108 kcal/kg/d)	4-6 yr (90 kcal/kg/d)	Pregnant/2nd & 3rd trimesters (36 kcal/kg/d + 300 kcal)
6-12 months (98 kcal/kg/d)		Lactating (36 kcal/kg/d + 500 kcal)

4. RD writes initials, dates, and checks incomplete, if there is information missing.
5. RD calls HCP office to obtain missing information.
6. RD or CPA checks one of three actions: Approved, Denied or Incomplete.
7. RD or CPA records the beginning and ending dates for the approved ENPR.
8. RD or CPA enters the ENPR data into AKWIC ENPR tab.
9. **If Medicaid eligible**, RD or CPA sends approved ENPR for formula or medical foods to a Medicaid Durable Medical Equipment (DME) Provider, or verify with HCP that ENPR request has been submitted to DME.
10. RD or CPA files the original ENPR form in the patient's WIC file or keeps copy in a central file.
11. Ask WIC participant to let the WIC clinic know as soon as Medicaid approves their ENPR. **To download go to:** <http://www.hss.state.ak.us/dpa/programs/nutri/WIC/LocalAgencies/LAENPRForms.htm>